DOCUMENT RESUME

ED 295 106 CG 020 846

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TITLE Teenage Pregnancy: Issues and Strategies for School Counselors.
PUB DATE Oct 87
NOTE 13p.
PUB TYPE Information Analyses (070)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Counselor Role; *Developmental Programs; *Early Parenthood; *Pregnancy; *Prevention; *Program Effectiveness; *School Counselors; Secondary Education; Sex Education
IDENTIFIERS *School Based Clinics

ABSTRACT

Many school administrators view teenage pregnancy as a top problems facing their school systems. Programs designed to reduce the teenage pregnancy rate must address multiple factors connected with teenage pregnancy. School-based clinic programs provide comprehensive primary health care for low income youth, require parental consent, provide mental health and psychosocial counseling, distribute birth control information and methods, operate in cooperation with public health agencies or hospitals, and are staffed by nurses and social workers backed by physicians. Developmental programs are focused on high risk for pregnancy teenagers; are usually school-based; and work to enhance academic skills, build self-esteem, and facilitate educational and occupational goal setting. Instructional type sex education programs have been shown to increase knowledge but neither increase nor decrease the teenage pregnancy rate, while some comprehensive school-based clinics and developmental programs have been effective in reducing the teenage pregnancy rate. School counselors can support the implementation of such comprehensive programs and can implement additional single purpose programs to build self-esteem, improve academic skills, help students set goals, and present alternate life styles. If these things cannot be done, school counselors can inform others of the scope of the teenage pregnancy problem and of the need to more effectively serve those adolescents who are at high risk for becoming pregnant. (NB)

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CG 020846

Teenage Pregnancy:
Issues and Strategies for School Counselors

Symposium Presentation

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Teenage Pregnancy:

Issues and Strategies for School Counselors

Research studies confirm that more teens today are sexually active and at risk of pregnancy than 10 or 15 years ago. In conjunction, many school administrators view teen pregnancy as one of the top 10 problems facing their school systems (Kenney, 1987). This is not surprising when it is considered that four of every ten females in the United States become pregnant before they turn twenty years old (Kenny, 1987). The National Center for Health Statistics estimated that across all socioeconomic groups and races there are 1.1 million teen pregnancies annually in the United States (Ladner, 1987). This situation has become problematic because of the increasing cost to the public, the impact on educational attainment, employment, and income, and the realization that it is a primary contributor to the cause(s) of poverty.

Burt (1986) calculated that "the public will pay an average of $13,902 per family over the next 20 years for the family begun by a teenager in 1985" (p. 221). Additionally, Burt found that in 1985 the total cost to the public was $16.65 billion for all women who gave birth as teenagers and received benefits from one or more of the following programs: Aid to Families with Dependent Children, Medicaid and Food Stamps.

The schooling experience for many teenagers who become pregnant is often terminally interrupted. In 1985, Mott and Marsigilo found that only one-half of women who gave birth at age 17 eventually completed high school while still in their twenties and that fewer than one-half eventually completed high school of those who were below 17 years when they gave birth. According to Kenny (1987) the result of this situation is that women who drop out are likely to find only low paying jobs since they do not possess higher level skills. Consequently, many pregnant teens who drop out exist in impoverished financial and educational conditions. In 1981, the Alan Gutmacher Institute reported that of "all families with children less than 6 years of age and headed by mothers who gave birth as teens, 67% live below the poverty level" (Journal of Home Economics, 1986, p. 42).

The following information suggests that if women would delay the birth of their first child until age 20 the positive impact on society would be significant. For example, Burt (1986) estimated that "the potential savings to the public would have been $5,560 for each birth delayed and $2.06 billion for the entire cohort of teens who would have otherwise had a 1st birth in 1985" (p. 221). Further, Mott and Marsigilo (1985) found that of women who waited to age 20 to have the first child, 90% attained a high school diploma.

In light of this data the need for teens to delay their first birth to at least age 20 is compelling. Further, the

National Research Council (NRC) of the National Academy of Sciences issued a major report in 1987 entitled Risking the Future: Adolescent Sexuality, Pregnancy and Childbearing which emphasized that programs and policies designed to address teen pregnancy should make pregnancy prevention their highest priority.

The most effective way to encourage teens to delay pregnancy appears to be to programmatically address the reasons they become pregnant. Proctor (1987) identified 13 factors associated with teens who become pregnant:

1. percieved poor relationship with a parent
2. recently experienced loss or change
3. prior pregnancy
4. history of non attendance at school
5. mother, sister or grandmother pregnant as a teen
6. history of sexual abuse
7. few, if any, girl friends
8. older boy friend
9. parental conflict or familial conflict
10. substance use or abuse
11. scholastic underachievement
12. looking/feeling unacceptable, different or inferior
13. low self esteem

Alvarez, Burrows, Zvarghut and Muzzio (1987) would add to Proctor's listing the factors of:

14. severely limited future prospects
15. tendency to live in the present

16. limited vision of the future

From review of this list it is apparent that the reasons teens become pregnant are interrelated and that individual teens have different combinations of the factors influencing their decisions to become sexually active and pregnant. Specifically, this suggests that because there are multiple factors involved in teens becoming pregnant that programs designed to reduce the rate of teen pregnancy or to delay the first birth must address the multiple factors connected with teen pregnancy. In an article which analyzed the impact of teen pregnancy on the education of black students, Ladner (1987) stated that "the most effective approaches to teen pregnancy prevention are those that emphasize a variety of strategies including education and training, jobs, sex and family life education, life skills training, peer counseling and male responsibility counseling with equal emphasis on the needs of females and males" (p. 58). Plus, to promote positive outcomes for teen parents, and their children, the NRC (1987) recommended a broad array of special programs and services to assist in the completion of education and other needed support services.

Research which is now becoming available shows that the more comprehensive approaches which go beyond instruction have been successful in lowering the rate of teen pregnancy. These programs fall into two groups, the school-based clinic (SBC) approaches and the developmental approaches.

SBC programs provide comprehensive primary health care for low income youth (general physicals, lab tests, diagnosis and treatment of injuries, nutrition and weight reduction programs, prescription of medication), require parental consent, provide mental health and psychosocial counseling, distribute birth control information and methods, operate in cooperation with public health agencies or hospitals and are staffed by nurses and social workers backed by physicians (Children's Defence Fund, CDF, 1986; Lovick, 1987; Kenny, 1987).

The oldest SBC, The Adolescent Health Services Programs/St. Paul Maternal and Infant Care Project in Minnesota reported that between 1976-77 and 1984-85 the birthrate among students in schools with clinics declined from 59 per 1000 births to 37 per 1000 births (Kenny, 1987). In the same time period the percent of female students who sought birth control increased from 7% to 35% (CDF, 1986; Kenny, 1987).

The data on another SBC program, The Self Center/Johns Hopkins Adolescent Pregnancy Prevention Program in Baltimore show that clinic schools had a 25.6% decline in pregnancy rates for students who participated two or more years while non-clinic schools which made up the control group had an increase in the rate of pregnancy of 51.2% (CDF, 1986).

Approximately 160 other school systems throughout the nation are following the SBC trend (Lovick & Wesson, 1986). The Los Angeles and Chicago systems are examples. At

Chicago's DuSable High School school officials dispense contraceptives to students who have parental permission. The school serves one of the nation's poorest neighborhoods and is battling an epidemic insofar as one-third of its 1,000 female students become pregnant each year. Although a lot of controversy has errupted from this practice, it has proven to keep many of the girls in school and off welfare (Stengel, 1985).

Developmental programs are focused on high risk for pregnancy teens, usually school based, enhance academic skills, build self-esteem and facilitate educational and occupational goal setting (CDF, 1986). The following four programs are examples of developmental programs.

The Teen Outreach Program in St. Louis is based on the belief that hightened self-esteem makes one less likely to drop out of school or become pregnant. The focus of the program is on life management skills and a range of topics including sexuality, self-esteem building, career planning, substance abuse and child abuse. Comparison with a control group revealed that Teen Outreach participants were less likely to get pregnant or fail school courses (CDF, 1986; Kenny, 1987).

The Summer Training and Education Program (STEP) in Philadelphia is designed to increase academic achievement and career awareness and enhance responsible decisions about sexual behavior. The program consists of four components: self pacing, remediation, work, life planning and social

support. Research on the program shows increased academic knowledge and increased knowledge about birth control and the consequences of early parenting (CDF, 1986).

A drop out prevention program, Rich's Academy in Atlanta operates as a school of last resort for 50 students who are failing or dropping out. The program provides intensive educational and social service support at the instructional site. In 1985, 24 graduated from high school and 19 of them were placed in jobs (6 of those enrolled in college) and 5 enlisted in branches of the military services (CDF, 1986).

Another developmental program, the Each One/Reach One Program and the Youth Motivation and Education Seminar in Milwaukee provides group counseling and role models for black girls ages 7-17 living in housing projects. The goal is to aid girls in making informed decisions about their lives. The group work covers self-concept, sexuality, hygiene, long range planning, careers, and behavior. The role models are black professional women who each spend 10 hours a month exposing a girl to alternative life styles. From 1981-1986, the program served 93 girls and only one had gotten pregnant. The results were especially significant because all the girls came from single parent homes and 87% were born to teenage mothers (CDF, 1986).

Many more SBC's and developmental programs than reported here have been implemented, but most of them have not evaluated their effectiveness due to the brief time they

have been operational. However, research that is available shows: 1) Instructional type sex education programs increase knowledge but they neither increase or decrease the rate of teenage pregnancy; 2) Some comprehensive SBC's are effective in reducing the rate of teen pregnancy; 3) Some comprehensive developmentally oriented intervention programs reduce the rate of teen pregnancy; 4) Programs effective in reducing the rate of teen pregnancy are comprehensive in nature with regard to addressing the causative factors associated with teen pregnancy; 5) Programs effective in reducing the rate of teen pregnancy successfully combine the resources of the school, social service agencies, health services and businesses within their respective communities.

Implications for Counselors

When it is considered that Georgia ranks fifth nationally in terms of high rate of teen pregnancy (Bachtel, 1985) and that various school boards have found it necessary to become involved in this problem, Georgia school counselors must ask what can I do? Possible responses which emerge from the research are: 1) School counselors can stimulate and/or support with all their clout the implementation of programs which are far more comprehensive than school sex education programs. The sex education programs which exist in schools should be incorporated into more comprehensive approaches to delay teen pregnancy; 2) School counselors can implement additional single purpose programs to build self-esteem, enhance self-concept, improve

academic skills, prevent dropout, help students set educational and occupational goals and present alternate life styles through contact with role models. With regard to this option, Kenny's (1987) caveat that initiatives not specifically designed "to reduce the incidence of teen pregnancy can hardly be expected to achieve that goal" (p. 736) should be taken seriously.; 3) If these things cannot be done then school counselors could inform others of the scope of the teen pregnancy problem and the need to more effectively serve those teens who are high risk for becoming pregnant.

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